

SIHFW Rajasthan

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From the Director's Desk

Dear Readers

Greetings from SIHFW, Rajasthan!

Every year, 31 May is marked as World No Tobacco Day by WHO. This day highlights the health risks associated with tobacco use and advocates for effective policies to reduce tobacco consumption. Tobacco use is the single most preventable cause of death globally and is currently responsible for killing one in 10 adults worldwide. The theme for World No Tobacco Day 2013 is: ban tobacco advertising, promotion and sponsorship.



Director

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Health Days in May '13

International Labour Day 1 May
International Red Cross Day 8 May
International Nurses Day 12 May
World No Tobacco Day 31 May

Welcoming! Dr Sanjay Saxena, Registrar-SIHFW



Dr Sanjay Saxena took the charge of SIHFW Registrar on 8 April 2013.

Dr Saxena is an M.B.,B.S. along with Diploma in Public Health Management and Health & Family Welfare Management. As a Medical Officer, he has been posted at various levels within State Health Services and also worked as Consultant UNICEF, SPO in IPD Project, District Programme Coordinator in RHSDP, Officer In charge MNDY, Jaipur.

He has vast experience in project development, implementation, monitoring & evaluation.

He has been a part of various national and international levels of trainings, seminars and workshops. He has also published various books, articles and research papers.

SIHFW family welcomes the new Registrar!.

Tobacco appears to be as old as human civilization; the spread of tobacco usage in the sixteenth and seventeenth centuries was part of the global drug convergence resulting from European voyages, discovery, expanded trade and the colonial plantation system. As tobacco gained in popularity, users learned to combine it with more familiar substances, often smoking or chewing them together. Tobacco was first introduced in India by Portuguese traders during AD 1600. Soon after its introduction, tobacco became a valuable commodity of exchange. The versatile uses of tobacco made it popular across the globe and enabled its acceptability in various socio-cultural contexts around the world. Its use and production proliferated to such an extent that overall, there are about 1.1 billion smokers worldwide. Today India is the second largest producer of tobacco in the world and the third largest consumer.

The tobacco epidemic is one of the biggest public health threats the world has ever faced. It kills nearly 6 million people a year of whom more than 5 million are from direct tobacco use and more than 600 000 are nonsmokers exposed to second-hand smoke. Approximately one person dies every six seconds due to tobacco and this accounts for one in 10 adult deaths. Up to half of current users will eventually die of a tobacco-related disease. Of these, nearly 80% of the more than one billion smokers worldwide live in low- and middle-income countries, where the burden of tobacco-related illness and death is heaviest.

The Global Adult Tobacco Survey (GATS) is one of the components of the Global Tobacco Surveillance System (GTSS). GATS is a standardized household survey that enables countries to collect data on key tobacco control indicators and assist countries in the formulation, tracking and implementation of effective tobacco control interventions and international comparisons as laid out in the MPOWER policy package of the World Health Organization (WHO). World Health Organisation is committed to fight the global tobacco epidemic. The organisation predicts that tobacco deaths in India may exceed 1.5 million annually by 2020. The WHO Framework Convention on Tobacco Control (FCTC) entered into force in February 2005. With 176 Parties covering 88% of the world's population, the WHO Framework Convention is WHO's most important tobacco control tool and a milestone in the promotion of public health.

World Health Organisation (WHO) aims to scale up the provisions under FCTC through application of MPOWER measures. Each MPOWER measure corresponds to at least one provision of the WHO Framework Convention on Tobacco Control.

The six MPOWER measures are:

- Monitor tobacco use and prevention policies
- Protect people from tobacco use
- Offer help to quit tobacco use
- Warn about the dangers of tobacco
- Enforce bans on tobacco advertising, promotion and sponsorship
- Raise taxes on tobacco.

“Ban tobacco advertising, promotion and sponsorship”; with this theme for World No Tobacco Day 2013, World Health Organisation (WHO) and partners everywhere mark World No Tobacco Day, highlighting the health risks associated with tobacco use and advocating for effective policies to reduce tobacco consumption.

The theme for the year signifies a comprehensive ban of all tobacco advertising, promotion and sponsorship under the WHO Framework Convention for Tobacco Control (WHO FCTC) for all Parties to this treaty within five years of the entry into force of the Convention for that Party. Evidence shows that comprehensive advertising bans lead to reductions in the numbers of people starting and continuing smoking. Statistics show that banning tobacco advertising and sponsorship is one of the most cost-effective ways to reduce tobacco demand and thus a tobacco control “best buy”.

Tobacco usage in India: Current Scenario

In the 21st century, India has come amongst the countries most affected by tobacco-related mortality. Having nearly 275 million tobacco users, India ranks second globally and very close to China (approximately 301 million users). But unlike China, where nearly all are smokers and nearly 95 per cent

smoke manufactured cigarettes, India accounts for more of smokeless tobacco users — 206 million (a study published in *The Lancet* August 17, 2012).

The total users includes more than one-third of adults (34.6 per cent) (age 15+) using some form of tobacco, including almost half of men (48 percent) and 20 percent of women. In India, the onset of tobacco use typically occurs in adolescence; among youth (age 13-15), 4 percent smoke cigarettes and almost 12 percent use other types of tobacco products. *Bidis*, cheap hand-rolled cigarettes, are the most popular tobacco product used in India. *Bidis* comprise 48 percent of the tobacco market, chewing tobacco 38 percent and cigarettes 14 percent.

It is anticipated that nearly 1 million Indians will die annually from smoking by 2010, with 70% of those deaths prematurely occurring among people between the ages of 30 and 69 years.

	Current Tobacco users	Smoked only	Smokeless only	Both
Rajasthan				
Men	50.5	21.8	19.0	9.7
Women	12.9	4.5	7.6	0.8
India				
Men	47.9	15.0	23.6	9.3
Women	20.3	1.9	17.3	1.1

(Source: Global Adult Tobacco Survey-India, 2009-10)

Tobacco usage in Rajasthan:

Rajasthan has 32.3% of Adult current tobacco users (28.4 % Daily Users & 3.9% Occasional users). Percentage of Male and Female age 15 and above, who are current tobacco users are 50.5% and 12.9% respectively. Mean number of cigarettes and bidis smoked per day in Rajasthan is 5.8 and 16.2 against 6.2 and 11.6 in India. Mean age of initiation among ever daily tobacco users age 20-34 yrs is 17 years (India-17.8 years). The use of smokeless tobacco in Rajasthan is 28.7% against 32.9% in India.

Source- Global Adult Tobacco Survey (GATS) India Report 2009-10

Gender Wise distribution of tobacco usage: India V/s Rajasthan

While the mean age for initiation of any form of tobacco usage is 17.8 years in India, Rajasthan is no less with 17 years. In terms of productivity loss, it is estimated that total loss of cost due to tobacco (inclusive of productivity loss) amounts to Rs. 7735 crores. Surprisingly, the total estimated loss was calculated to be 16 % more than the total revenue collected through the excise on all the tobacco products.

(Source- Global Adult Tobacco Survey (GATS) India Report 2009-10)

Forms of Tobacco

- Tobacco The rules provide that the owner, proprietor or the manager of all the public places shall ensure that no person smokes in the prohibited area under his jurisdiction. It also calls for assign board to be displayed at the entrance of the premises on each floor including the staircase and enhance to the lift.
- Detailed provisions have been incorporated for strict implementation of the prohibitory orders.
- The manager of the establishment is liable to be find for any violation by any person of the above prohibition
- The head of the institution/HR manager/Head of administration has to be designated/authorised to prohibit smoking at offices and workplaces
- Ashtray, match boxes, lighters or other things designed to facilitate smoking should not be provided at the workplace.

It will be necessary for the managers to display in the establishment prominently, the name of the person to whom complaints can be madehas been used in India for centuries. Early forms of tobacco were

limited to chewing tobacco leaves or smoking tobacco. Today, several products made of, or containing tobacco, are available in the market. More than 4,000 different chemicals have been found in tobacco and tobacco smoke. More than 60 of these chemicals are known to cause cancer (carcinogens). Nicotine is a drug found in tobacco. It is highly addictive – as addictive as heroin or cocaine. Over time, a person becomes physically and emotionally addicted to, or dependent on, nicotine.

Tobacco is commonly used in two forms: Smoked and Smokeless tobacco. The major smoked tobacco products include ciggrates, *bidis*, cigars, hookah and *chillam* while the commonly used smokeless form of tobacco includes betal quid with tobacco, *khaini* or tobacco lime mixture, *gutkha*, *paan masala*, *mawa* (combination of areca nut mixture and scented tobacco and slaked lime), and oral tobacco (snuff, *mishri*, *gul*, *gudakhu* etc.).

Tobacco usage and health risks

The health effects of tobacco are the circumstances, mechanisms, and factors of tobacco consumption on human health. There is strong evidence that tobacco usage is related to many diseases and conditions. Many organs and body systems are adversely affected by tobacco smoke. Fortunately, most of this starts to reverse after a smoker quits smoking.

All smokers are at extra risk for Coronary heart disease (e.g., heart attacks), Peripheral vascular disease (circulatory problems), Aortic aneurysm, High cholesterol (LDL), Lung cancer, Cancer of the mouth, throat and voice box, Cancer of the pancreas, Cancer of the kidney, and urinary bladder, Chronic obstructive pulmonary disease (COPD), Chronic bronchitis, Emphysema, Pneumonia, Influenza (the "flu"), The common cold, Peptic ulcers, Chronic bowel disease (Crohn's disease), Tooth decay (cavities), Gum disease, Osteoporosis, Sleep problems (falling asleep inappropriately and/or frequent waking), Cataracts and Thyroid disease (Grave's Disease).

Other Effects

- Several recent reports provide strong evidence of an association between smoking and osteoporosis (decreased bone density), which, in turn, predisposes a person to bone fractures. Smoking is independently associated with decreased bone density of the lumbar spine and hip, in both younger and older persons.
- Smoking has been linked to sleep disturbance. Smoking is associated with difficulty in falling asleep and with symptoms suggestive of sleep fragmentation in both men and women.
- Evidence of a link between cataracts and smoking continues to grow. An association may also exist between smoking and a type of thyroid disease (Graves' disease).
- Smoking may be a detriment to physical fitness, even among relatively fit, young individuals. Smoking reduces the ability of the blood to carry oxygen and increases the heart rate and basal metabolic rate, thus counteracting the benefits of physical activity, including cardiovascular fitness.
- Smoking decreases blood flow in the small vessels of the skin, perhaps damaging skin components, and leading to skin wrinkling and an appearance of premature aging in both men and women.

Indian initiatives to control tobacco usage

India became a Party to the WHO Framework Convention on Tobacco Control on February 5, 2004. Government of India has enacted the Anti-tobacco Law, (The Cigarettes and other Tobacco Products Act) (COTPA 2003) with a view to discourage consumption of tobacco products by imposing various regulatory measures. Further, under food safety regulations, tobacco products such as Gutkha and Pan Masala containing tobacco and Nicotine have been prohibited. Government of India has also launched the Revised National Tobacco control Programme (RNTCP) in 2007-08 which, at present, covers 692 districts, and 35 states and Union territories. Since inception, RNTCP has evaluated over 55 million persons for TB and initiated treatment for over 15.8 million TB patients.

Source: TB India 2013(RNTCP Annual Status Report)

Cigarette and Other Tobacco Product Act, 2003 & Prohibition of Smoking in Public Places Rules, 2008

On October 2, 2008, the Indian Government expanded the prohibition on smoking in public places and workplaces to protect individuals from the hazards of secondhand tobacco smoke. Salient features of the rule:

- Restrictions with regard to smoking apply clearly to hotels, restaurants, refreshments rooms, public places etc which would also include workplaces among other places as defined in each category. Section 4 of the act envisage separately ventilated smoking room termed as “Smoking Area”
- by the person for violating the provision of these rules.



Rajasthan to prepare vision 2025 for tobacco control

The state government will prepare vision 2025 for tobacco control. The decision was taken in a meeting of state-level coordination committee (SLCC). A workshop will be conducted for Vision 2025 and ways to control sale and production of tobacco products and implement cigarettes and other tobacco products act (COTPA) will be discussed.

SIHFW in Action

Workshop on Flagship schemes

A once-day workshop on flagship schemes of the Government of Rajasthan was convened at SIHFW on April 16, 2013.

Brief report of Mukhyamantri Nishulk Dava Yojana (MNDY) and Mukhyamantri Nishulk Janch Yojana (MNJY), relevant issues and suggestions of various stakeholders were discussed at the workshop.

At the workshop, Janani Shishu Suraksha Yojana (JSSY) was reviewed by Smt Gayatri Rathore, by MD NRHM. Dr Samit Sharma, MD, RMSC delivered a session on MNJY lessons, log-term activities for Ph-1 institutes, and preparation of Ph-II (CHCs) and Ph-III (PHCs). 162 participants including CMHOs, Government Health Officials and Consultants were present at the workshop.

The workshop was chaired by Sh Deepak Upreti, Principal Secretary, Health.



Trainings/workshops organized:

S. No.	Date	Title	Cadre (Total Participants)	Sponsoring Agency
1.	2-4, 16-18, April 2013	Routine Immunization at SIHFW	31 (MOs)	DM&HS
2.	23-25 April 2013	Training on RI for staff of Save the Children	16 (M&E Officers)	Save the Children
3.	16-April 2013	Workshop on Flagship Schemes of Medical & Health Department, GoR	162(CM&HO)	DM&HS
4.	17-April 2013	Quarterly Review Meeting of RCHOs	55(RCHO)	DM&HS
5.	April 25-July3,2013	Professional Development Course	14(MO/SMO/JS)	NIHFW

Meeting of the Executive Committee

Meeting of the 29th Executive Committee was held at Department of Medical Health and Family Welfare, Jaipur on April 12, 2013. The meeting was chaired by, Sh Deepak Upreti, Principal Secretary, Health. All seven Executive Committee members were present at the meet.

Declaration: Integrated training to be continued in year 2013-14 as per the approval of PIP.

Monitoring/Field Visits**Workshop at Goa**

Dr Mamta Chauhan, Faculty, participated at the Management development Programme on 'Management and Leadership' at Goa. The programme was organized by International Union against Tuberculosis and Lung disease. It was a national level programme.

Celebration

Month of April was a 'Birthday Month' at SIHFW, where during the month; four Birthdays were celebrated with fruit delights, fun and frolics!

Birthday of Dr Richa Chaturvedy was celebrated on April 10 2013, and of Ms Reena Miglani was celebrated on April 24 2013.

Ms Archana Saxena's and Dr Shweta Sharma's birthdays were celebrated on April 28 and April 30, 2013.



The Forthcoming

1. Training of Professional Development Course at SIHFW from April 25 to July 3, 2013.
2. Integrated EmOC Training at Zanana Hospital, Jaipur , March 30 to August 2,2013
3. One day workshop on Safe abortion services at SIHFW, March 15,2013
4. Training on Routine Immunization at SIHFW, April 30 to May 02, May 7 to 9, May14 to 16,May 21 to 23,May 28 to 30,2013
5. Training on National Cold Chain Management Information System (NCCMIS) at SIHFW, May 6 to 8,9 to 11, May 30 to June 1, 2013

Feedback

1. Hostel facility is best
2. Internet and computer facility were good
3. Food was good
4. Training hall is good

(Source: feedback forms RI training, April 2-4, 16-18, 2013)

Global

Hypertension: pay attention

Data from different national and regional surveys show that hypertension is common in developing countries, particularly in urban areas, but the rates of awareness, treatment and control are low. It is possibly caused by urbanisation, an ageing population, changes in dietary habits, and social stress. High illiteracy rates, poor access to health facilities, bad dietary habits, poverty, and high costs of drugs contribute to poor blood pressure control.

Almost three-quarters of people with hypertension (639 million people) live in developing countries with limited health resources. In India, hypertension has increased by 30 times in urban populations over 25 years, and by 10 times in rural populations over 36 years. Many people have no signs or symptoms, even if the blood pressure readings reach dangerously high levels.

There's no identifiable cause of high blood pressure in most people. Called essential hypertension or primary hypertension, it develops gradually over many years. Some people have high blood pressure caused by an underlying condition. This is secondary hypertension, appears suddenly and causes higher blood pressure than does primary hypertension. Various conditions and medications can lead to secondary hypertension, including kidney problems, adrenal gland tumors, certain defects in blood vessels (congenital) and illegal drugs such as cocaine and amphetamines.

Uncontrolled high blood pressure can lead to heart attack or stroke; aneurysm and heart failure; weakened and narrowed blood vessels in kidneys; thickened, narrowed or torn blood vessels in the eyes; metabolic syndrome; and trouble with memory or understanding.

The primary health-care systems, mainly in developing countries, are often without the most basic equipment, such as a calibrated and functioning sphygmomanometer or a glucometer. Another reason for poor awareness is that hypertension, as an asymptomatic disease, contrasts with the most common clinical situations faced daily by the primary health-care workers. Measurement of blood pressure is seen as a secondary task and is not systematically done. As a result, hypertension is not often diagnosed. A deficient procurement and distribution process of essential drugs for treatment of hypertension is also common.

The three most important steps to increase hypertension control are the use of primary health care centre as the key point of control, deployment of nurses as the main human resource for diagnosis and follow-up and the adoption of a global cardiovascular risk approach as a strategy for treatment.

Governments should make a special effort to supply basic drugs for treatment of hypertension at the primary health level at a fair price. Together with medical societies and non-government organisations, they should promote preventive programmes aimed at increasing public awareness, educating physicians, and reducing the intake of salt. Regulations of the food industry and the production and availability of generic drugs should be reinforced. A reliable, durable, and largely affordable sphygmomanometer that can be widely used at the primary health-care level is urgently needed.

Source: TH. 07.04.13

India

Bihar records highest fertility rate in India

Bihar has recorded highest fertility rate in the country with an average rural woman in the State giving birth to almost four children. This, even as the national level total fertility rate (TFR) has dipped by .1 points to 2.4 in 2011. For the record, Bihar at 51.1 has the highest percentage of illiterate women in the country.

In comparison, Tamil Nadu and West Bengal have reported the lowest TFR at 1.7 against the national average. In 2010, the country's TFR was 2.5 against 5.2 in 1971.

TFR indicates the average number of children expected to be born per woman during her entire span of reproductive period assuming that the age specific fertility rates, to which she is exposed to, continue to be the same and that there is no mortality.

State wise, Bihar has reported highest TFR of 3.7 followed by Uttar Pradesh, Rajasthan and Madhya Pradesh with TFR of 3.4, 3.1 and 3 respectively, as per the survey by the Registrar General of India (RGI).

It is the largest demographic survey in the world covering about 1.5 million households and 7.35 million population.

Around eight States have already reached the replacement level TFR of 2.1. The TFR for India in the year 2011 was 2.4 per woman and varies from 2.7 in rural areas to 1.9 in urban areas.

The TFR has declined from 5.2 to 4.5 during 1971 to 1981 and from 3.6 to 2.4 during 1991 to 2011. The TFR in rural areas has declined from 5.4 to 2.7 from 1971 to 2011 whereas the corresponding decline in urban areas has been from 4.1 to 1.9 during the same period.

As per the National Population Policy, India was to reach the national TFR of 2.1 by 2010, but now it expects to reach population stabilization by 2060, with 165 crore people.

Source: The Pioneer, 04.04.13

India moves ahead to get WHO's polio eradication certificate

Having successfully completed two polio-free years, India is preparing to receive the crucial polio eradication certificate from the World Health Organization (WHO).

The certificate is issued on completion of incident-free three years. This primarily involves the destruction or safe storage of all laboratory sources of wild poliovirus. The storage should be in laboratories that meet international standards of bio safety.

To achieve this, the Ministry of Health and Family Welfare has set up a National Task Force for Containment of Wild Poliovirus. Chaired by the Director-General of the Indian Council of Medical Research (ICMR), it will identify laboratories that could store wild poliovirus or potentially infectious material.

Wild poliovirus could be present in certain types of clinical samples stored at or below minus 20 degrees Celsius. These could have been collected for investigations not related to wild poliovirus detections. There are several medical colleges/universities, colleges and research institutions that work on infectious material and, therefore, have clinical samples collected over several decades. Information from these institutions will be collected and compiled for preparing a national inventory.

The process has to be completed by December and failure to do so will delay the certification process. Cabinet Secretary Ajit Seth has personally written to the Chief Secretaries of State governments on behalf of the Health Ministry, seeking their cooperation in taking the process forward with a sense of extreme urgency. A pre-tested form has been sent to all laboratories and institutions to elicit information on wild poliovirus.

The WHO's Global Action Plan for containment of wild polioviruses advises that when polio cases are decreasing, national health authorities must alert laboratories, encourage destruction of all unneeded wild poliovirus material and compile an inventory of all laboratories retaining such materials.

Source: T.H.08.04.13

Rajasthan

Rajasthan to prepare vision 2025 for tobacco control

After Jhunjhunu, Jodhpur is the second city to earn the smoke free tag to ensuring a strict compliance to the Cigarettes and Other Tobacco Products Act (COTPA). Jai Narain Vyas University conducted the survey and found above 90% compliance of COTPA. In Jodhpur, the compliance of section 5 of COTPA, which prohibits direct or indirect advertisement, sponsorship and promotion of tobacco products, was an impressive 98%.

National Rural Health Mission (NRHM), Director, Gayatri Rathore said the health department has stepped up efforts for implementing COTPA with the help of NGOs. She also said that Rajasthan is the first state which has constituted a SLCC for tobacco control.

The district administration removed all the advertisement boards of tobacco products from shops selling the items. Recently, the administration held a meeting with leading companies selling tobacco products and directed them to remove the advertisement boards of tobacco products to help in implementation of the COTPA.

Around 400 violators of COTPA were *challan was made*. Separate smoking zones in hotels were set up.

Source: TOI, 27 April, 2013



We solicit your feedback:

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